

# **Vermont Department of Aging & Disabilities**

## **Case Management Standards**

*The following standards were written to provide guidance for case managers and to describe acceptable case management. These standards apply to case management services provided to adults 60 years of age and older and to younger adults with disabilities through the Home and Community Based Medicaid Waiver, Enhanced Residential Care Waiver and Older Americans Act.*

### **A. Goal of Case Management**

To ensure that older adults and younger adults with disabilities receive appropriate, effective and efficient services, allowing them to retain or achieve the maximum amount of independence possible and desired.

### **B. Definition of Case Management**

Case management is a professional service to help older adults and younger adults with disabilities access the services they need to remain as independent as possible in accordance with the wishes of the individual, and/or working with a legal representative of that individual, and advocating on behalf of that individual for needed services or resources. Case management targets those individuals with psychosocial or medical needs that extend beyond either advocacy counseling, public benefits or financial issues. Case management includes:

1. completing a comprehensive assessment to identify the individual's strengths and needs, (including the physical, psychological, financial, and social needs of the individual) and discussing and offering options;
2. arranging for and coordinating an efficient and effective package of services to meet the needs of the individual. This includes the development and implementation of an Action Plan/Care Plan with the individual and/or family to identify and access the formal and informal resources and services which are necessary to meet the identified needs of the individual;
3. monitoring the formal and informal services delivered to ensure that services specified in the plan are being provided and that the individual's identified needs are met; and
4. performing periodic reassessments of the individual with the individual and/or if necessary, with the primary caregiver or family member, and revising the Action Plan as needed.

### **C. Principles of Case Management**

1. Case management services promote self-determination, independence, and empowerment of older adults and younger adults with disabilities.
2. Case management services foster respect, dignity, privacy, and confidentiality for the individual being served.
3. Case management services respect individual rights, strengths, values and choices, encouraging individuals to direct and participate in their own Action Plans and services to the fullest extent possible.
4. Case management services respect individual self-determination, including the opportunity for individuals to decide whether or not to participate in a program, service or activity.
5. Case management services are provided in an efficient manner, preventing duplication of services to maximize the benefits and services available to all individuals.
6. Case management services respect the right of individuals to receive services under conditions of acceptable risk, in which the individuals assume the risk associated with decisions which they make through a process of informed consent.
7. Case management services will not be used to secure improper or inappropriate gain for the case manager or the case manager's employer.

### **D. Case Management Outcomes**

Quality case management services attempt to achieve the following outcomes:

1. The individual is aware of available options for which s/he is eligible and receives chosen services.
2. The individual expresses satisfaction with case management services.
3. If relevant, the individual's primary caregiver or family expresses satisfaction with case management services.
4. The individual's Action Plan is comprehensive and individualized.
5. The individual expresses satisfaction with her/his level of involvement in the development of the Action Plan.

6. The services are provided in an efficient and effective manner, and duplication of effort and services are minimized.

## **E. Case Management Standards**

1. The case manager will promote self-determination, independence, and empowerment of older adults and younger adults with disabilities.
2. To the extent possible, the case manager will ensure that an individual is being served in the least restrictive and most appropriate setting of her/his choice.
3. The case manager will respect individual rights, strengths, values and preferences, encouraging individuals to direct and participate in their Action Plans and services to the fullest extent possible.
  - a. Case managers will not make decisions for individuals. Where there is a legally appointed surrogate decision-maker and the individual is unable to participate in addressing an issue, assistance may be given to the surrogate's decision-maker.
  - b. It is the responsibility of the case manager to ensure that an individual has the right to receive services under conditions of acceptable risk in which the participant assumes the risk associated with decisions, which she/he makes under conditions of informed consent.
4. The case manager will be knowledgeable about services and ensure that individuals and caregivers are aware of available resources and services.
5. The case manager will provide services in an efficient and effective manner, to avoid duplication of services, unnecessary costs, and unnecessary administrative tasks.
6. The case manager will respond to requests for information and/or assistance from individuals, caregivers and/or third party referrals.
7. The case manager will assess, with the client's and/or surrogate decision-maker's consent, her/his circumstances, problem areas, and strengths using the assessment tool designated by the Department.
  - a. The case manager will initiate and oversee the initial assessment and reassessment of needs/strengths.
  - b. The assessment will evaluate the following areas: activities of daily living, instrumental activities of daily living, health status, finances, social/emotional status, living environment, existing formal/informal support services, and current program/services involvement.
  - c. Any immediate needs should be clearly identified and documented.

- d. For Area Agency on Aging case managers the initial Intake section of the assessment tool designated by the Department will be completed at the first face-to-face contact. Documentation will be recorded in the Client Record when this is not possible, as to why. Additional sections of the full assessment will be completed based upon the case manager's professional judgement for those individuals with needs that extend beyond advocacy counseling and/or benefit programs. In all cases, a thorough enough assessment must be completed to ensure that all needs are identified; however the full assessment form will always be completed for those individuals participating in Medicaid Waiver Programs.
  - e. The assessment will be updated at least annually; more frequently if there is a major change in the individual's circumstances.
8. The case manager will assist an individual and caregiver, (when appropriate) to develop and implement an Action Plan.
- a. Action Plans will be completed with individuals with complex case management needs that extend beyond advocacy and/or benefits counseling.
  - b. The Action Plan will address issues and goals, plan/strategy, the responsible person for each task, and the target date for each issue and goal.
  - c. The initial Action Plan will be completed at the first face-to-face contact, if possible. The Action Plan will be updated at the annual reassessment or more frequently if there is a major change in the individual's circumstances.
9. The case manager will, together with the individual and caregiver, (when appropriate) monitor all case management services, and changes in the individual's/caregiver's needs. The case manager will contact the individual/caregiver as indicated by the assessment and action plan, as needs arise, and/or as required by applicable program standards.
10. The case manager will maintain complete and accurate client files.
- a. Case manager's client files will contain a current release of information or an explanation of why a release of information could not be obtained. Permission, written or verbal, will be documented in the client file.
  - b. The case manager's client files will also contain copies of client records, intake/assessment forms, copies of the most current public benefit applications, and correspondence related to benefits and services.

11. The case manager will abide by the case manager's agency policy concerning conflicts of interest and the appearance of conflict of interest, between the interests of the individual and those of the case manager and/or the case manager's employer.
12. Case managers are mandated reporters. Case managers will follow Vermont statute 33 V.S.A. § 6903 regarding mandated reporting and case management agency policies.
13. Area Agency on Aging case managers will respond to a self-neglect referral within 48 hours. Situations that present as an emergency must be attended to immediately or referred to the appropriate resources.
14. The case manager will abide by principles of confidentiality as outlined in the case management agency policy.